ADVANCED VISION CARE, LLC

Dr. Joshua D. Wilson Dr. Michael K. Wilson

PLEASE PRESENT THIS INFORMATION ALONG WITH INSURANCE CARDS AND PHOTO IDENTIFICATION UPON OFFICE ARRIVAL

Name: _____ Nickname: _____ Gender: M / F

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: (___)_____ Cell: (___)_____ Work: (___)_____

May we send text messages to your cell? Y / N Email: _____

Preferred method of contact ? CALL (Home / Cell / Work) / TEXT / EMAIL

Occupation: _____ Employer: _____

Employment Status: Retired: _____ Full-Time: _____ Part-Time: _____ Unemployed: _____

Marital Status: S / M / D / W Children's Names & Ages:_____

Spouse: _____ Spouse's DOB: _____/_____/_____ Spouse's SSN: _____-_____-_____

Spouse's Employer: _____ Spouse's Employer Phone: (___)_____

If a patient is a minor, please enter responsible party information: (Note we do not bill absent parents, the adult presenting the minor is the responsible party.)

Responsible Party: _____ Employer: _____

Responsible Party's DOB: _____ Responsible Party's SSN: ____-____-_____

Policy Holder (**if different from responsible party**): _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN: _____/_____/_____

Employer of Policy Holder: _____ Work Phone: (____)_____

Patient's Relationship to Policy Holder: _____

May we share patient information with another person not listed above? Y / N

If yes, whom? _____

Patient Name: (Printed) _____

Patient/Guardian Signature: _____ Date: ____/___/_____

SOCIAL HISTORY

Do you use tobacco products? Y / N Drink alcohol? Y / N Use any illegal or recreational drugs? Y / N
If yes to any of above, type/amount/how long? _____

OCULAR HISTORY

How long since last eye exam ?_____ Doctor who performed exam: _____

Wear glasses? Y / N If so, how old is current pair?_____ Wear contact lenses? Y / N

If yes, what type (soft, gas perm, etc) & brand? _____ Sleep in them? Y / N / Occasionally

If you don't wear contacts, are you interested in them? Y / N Interested in refractive surgery? Y / N

Please specify if you personally or a family member has a history of the following:

EYES:	YES	NO	FAMILY, WHO?	EYES:	YES	NO	FAMILY, WHO?
Cataracts	[ ]	[ ]	[ ] _____	Tearing	[ ]	[ ]	[ ] _____
Macular Degeneration	[ ]	[ ]	[ ] _____	Discharge	[ ]	[ ]	[ ] _____
Glaucoma	[ ]	[ ]	[ ] _____	Blurred Vision	[ ]	[ ]	[ ] _____
Diabetic Retinopathy	[ ]	[ ]	[ ] _____	Eyestrain	[ ]	[ ]	[ ] _____
Dry Eye	[ ]	[ ]	[ ] _____	Eye Pain	[ ]	[ ]	[ ] _____
Eye Infection/Allergy	[ ]	[ ]	[ ] _____	Light Sensitivity	[ ]	[ ]	[ ] _____
Floaters/Flashes	[ ]	[ ]	[ ] _____	Headache	[ ]	[ ]	[ ] _____
Iritis/Uveitis	[ ]	[ ]	[ ] _____	Poor Night Vision	[ ]	[ ]	[ ] _____
Retina Defects	[ ]	[ ]	[ ] _____	Night Glare	[ ]	[ ]	[ ] _____
Redness	[ ]	[ ]	[ ] _____	Double Vision	[ ]	[ ]	[ ] _____
Buring	[ ]	[ ]	[ ] _____	Total Vision Loss	[ ]	[ ]	[ ] _____
Itching	[ ]	[ ]	[ ] _____	Lazy Eye	[ ]	[ ]	[ ] _____
Color Blindness	[ ]	[ ]	[ ] _____	Nystagmus	[ ]	[ ]	[ ] _____

Primary Care Physician: _____ Location/City:_____

Specialty Physician (e.g. Endocrinologist): _____ Location: _____

Pharmacy: _____ Location: _____

Please list ALL medications you are currently taking along with dosage, route, and reason (include OTC and eye drops):

Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____

Do you have any allergies to medications? Y / N
If yes, please list & explain type of reaction: _____

Please list all major surgeries & injuries, including dates: _____

Have you had any eye injuries, surgeries, or other significant eye problems (include dates)?

MEDICAL HISTORY

CONSTITUTIONAL	YES	NO	FAMILY, WHO?
Developmental Disabilities	( )	( )	( ) _____
Fatigue Syndrome	( )	( )	( ) _____
Cancer	( )	( )	( ) _____
Weight Flucuation	( )	( )	( ) _____
Fever/Chills	( )	( )	( ) _____
Trauma	( )	( )	( ) _____
Other _____			

EAR/NOSE/THROAT	YES	NO	FAMILY, WHO?
Hearing Loss	( )	( )	( ) _____
Sinusitis	( )	( )	( ) _____
Dry Mouth	( )	( )	( ) _____
Laryingitis	( )	( )	( ) _____
Ringing	( )	( )	( ) _____
Vertigo	( )	( )	( ) _____
Other _____			

NEUROLOGIC	YES	NO	FAMILY, WHO?
Multiple Sclerosis	( )	( )	( ) _____
Epilepsy	( )	( )	( ) _____
Cerebral Palsy	( )	( )	( ) _____
Tumor	( )	( )	( ) _____
Stroke/CVA	( )	( )	( ) _____
Migraine	( )	( )	( ) _____
Autism	( )	( )	( ) _____
Headaches	( )	( )	( ) _____
Memory Loss	( )	( )	( ) _____
Other _____			

PSYCHIATRIC	YES	NO	FAMILY, WHO?
Depression	( )	( )	( ) _____
Attention Deficit	( )	( )	( ) _____
Anxiety Disorder	( )	( )	( ) _____
Bipolar Disorder	( )	( )	( ) _____
Sleep Disorder	( )	( )	( ) _____
Other _____			

CARDIOVASCULAR	YES	NO	FAMILY, WHO?
Hypertension	( )	( )	( ) _____
Stroke/CVA	( )	( )	( ) _____
Heart Disease	( )	( )	( ) _____
Vascular Disease	( )	( )	( ) _____
Congestive Heart Failure	( )	( )	( ) _____
Other _____			

RESPIRATORY	YES	NO	FAMILY, WHO?
Cigarette Smoker	( )	( )	( ) _____
Asthma	( )	( )	( ) _____
Bronchitis	( )	( )	( ) _____
Emphysema	( )	( )	( ) _____
Chronic Obstruction	( )	( )	( ) _____
Sleep Apnea	( )	( )	( ) _____
Other _____			

GASTROINTESTINAL	YES	NO	FAMILY, WHO?
Crohn's Disease	( )	( )	( ) _____
Colitis	( )	( )	( ) _____
Ulcer	( )	( )	( ) _____
Acid Reflux	( )	( )	( ) _____
Celiac Disease	( )	( )	( ) _____
IBS/Digestive	( )	( )	( ) _____
Eating Disorder	( )	( )	( ) _____
Other _____			

GENITOURINARY	YES	NO	FAMILY,WHO?
Kidney Disease	( )	( )	( ) _____
Prostate Disease/Cancer	( )	( )	( ) _____
Pregnant	( )	( )	( ) _____
Nursing	( )	( )	( ) _____
STD	( )	( )	( ) _____
If yes list _____			
Other _____			

MUSCULOSKELETAL	YES	NO	FAMILY WHO?
Osteoarthritis	( )	( )	( ) _____
Arthritis	( )	( )	( ) _____
Fibromyalgia	( )	( )	( ) _____
Muscular Dystrophy	( )	( )	( ) _____
Ankylosing Spondylitis	( )	( )	( ) _____
Osteoporosis	( )	( )	( ) _____
Gout	( )	( )	( ) _____
Rheumatoid Arthritis	( )	( )	( ) _____
Muscle/Joint Pain	( )	( )	( ) _____

INTUGUMENTARY	YES	NO	FAMILY,WHO?
Eczema	( )	( )	( ) _____
Rosacea	( )	( )	( ) _____
Psoriasis	( )	( )	( ) _____
Herpes Simplex (Cold Sore)	( )	( )	( ) _____
Herpes Zoster (Shingles)	( )	( )	( ) _____
Cancer	( )	( )	( ) _____
Other _____			

ENDOCRINE	YES	NO	FAMILY,WHO?
Type 2 Diabetes	( )	( )	( ) _____
Type 1 Diabetes	( )	( )	( ) _____
Thyroid Dysfunction	( )	( )	( ) _____
Hormonal Dysfunction	( )	( )	( ) _____
Other _____			

BLOOD/LYMPHATIC	YES	NO	FAMILY,WHO?
Anemia	( )	( )	( ) _____
Blood Loss	( )	( )	( ) _____
Ulcer	( )	( )	( ) _____
Hypercholesteremia	( )	( )	( ) _____
Sjogren's	( )	( )	( ) _____
Leukemia	( )	( )	( ) _____
Other _____			

ALLERGIC/IMMUNE	YES	NO	FAMILY,WHO?
Drug Allergies	( )	( )	( ) _____
Enviromental Allergies	( )	( )	( ) _____
Rheumatoid Arthritis	( )	( )	( ) _____
Lupus	( )	( )	( ) _____
Sjogren's Syndrome	( )	( )	( ) _____
Food	( )	( )	( ) _____
Seasonal	( )	( )	( ) _____
Other _____			

PATIENT SIGNATURE:

_____

DATE: _____

PHYSICIAN INITIALS _____